BELFAIR
—of McAlester—
Senior Living's New Standard of Excellence

Move In Form

Resident: _____

Apartment #: _____ Move In Date: _____ 20_____

POA/Responsible Party: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Email: _____

Emergency Contacts

Name	Relationship	Home #	Cell #	City, State

Signature of POA/Responsible Party: _____

Just as a reminder – Financial responsibility ends when keys are turned in, apartment is vacated, and all personal belongings have been removed.

For example: If a resident moves out on December 1st but all belongings are removed on December 15th, financial responsibility ends on December 15th.

Belfair of McAlester, LLC, is not able to accept donations or store personal belongings.

BELFAIR
of McAlester
Senior Living's New Standard of Excellence

Belfair of McAlester, LLC, Monthly Outings

We provide various social and recreational activities both at and away from the community. We also will assist interested resident groups in planning additional activities. You are welcomed and encouraged to participate in such activities as you desire. There may be an extra charge for some of the activities away from the community that involve admission charges or fees. These charges will be included on your monthly billing.

Resident: _____

Resident/Responsible Party Signature: _____

Date: _____

BELFAIR
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MULTI-MEDIA CONSENT AND RELEASE

I, _____ (name) certify that I am of legal age and hereby authorize Belfair of McAlester, LLC, my Community, and those acting under their permission or authority the right to obtain, reproduce and otherwise use my statements, photographs, likenesses, video tapes and audio tapes (collectively, my "Image") for the purposes and in the media I have indicated with checkmarks below.

☐ Advertising/publicity (any published or electronic form, and in any medium of advertising, publicity or trade, including, without limitation, signage, broadcasts, the Community websites and social media website).

☐ Community Directory (in paper or electronic form, such as a website accessible only with password available to all Community residents).

My Image will not disclose my medical condition. I understand, however, that my Image could identify me as a potential or actual recipient of health care services from my Community. I therefore release my Community from liability under the privacy rules set by the Health Insurance Portability and Accountability Act (HIPPA) in connection with the use of my Image.

I understand that I will receive no compensation for the use of my Image. I waive any right that I may have to inspect or approve the finished product that may be used in connection with publication of my Image. I understand that I may revoke this consent at any time by informing my Community of my revocation in writing.

My signature below is voluntary, I have read and understand this consent and release and I verify that I am over 18 years of age.

_____ _____

Signature of Resident or Responsible Party Date

BELFAIR
of McAlester
Senior Living's New Standard of Excellence

Transportation Release

I hereby release Belfair of McAlester, LLC, its respective licensees, owners and successors of any and all liability regarding the transportation of my person, or the person I am legally bound to care for, to and from the community in the vehicle identified for this purpose.

Resident: _____

Resident/Responsible Party Signature: _____

Date: _____

BELFAIR
of McAlester
Senior Living's New Standard of Excellence

Resident Handbook

I have received, reviewed and by this signed acknowledgment, indicated my understanding of the information contained within the Belfair of McAlester, LLC, Resident Handbook.

Resident: _____

Resident/Responsible Party Signature: _____

Date: _____

BOOMER SOLUTIONS

Billing Agreement

Boomer Solutions Pharmacy services include but are not limited to providing prescriptions, maintaining and providing medication administration records, free delivery service, facility training services, consultations by our pharmacist, nursing staff, affiliates and 24-hour emergency service. IV training services may include venipuncture, catheter care, assessment and monitoring.

Itemized statements are sent out at the beginning of each month for the prescriptions sent the previous month. The statements reflect all costs not paid by the insurance including co-pays, and the cost of the prescription when the item was not covered by the insurance. The balance due is payable directly to Boomer Solutions Pharmacy upon receipt. Please circle the following as the primary method of payment

PAPER CHECK CREDIT OR DEBIT CARD ACH MONTHLY DEBIT

*If we do not receive a payment by the 15th of the month we will automatically default to your 2nd choice of payment.

**Please provide EITHER Credit/Debit Card OR Voided check/bank draft information. By providing this information you are agreeing for Boomer Solutions Pharmacy to charge any outstanding balance due on a monthly basis.

Any discrepancies shown on the statement must be communicated to the pharmacy within 30 days and we will attempt to resubmit the claim electronically. Depending on the plan, the claim may need to be manually submitted to the plan by the responsible party for reimbursement if the plan will not allow us to submit the claim electronically. Each plan has different limits on how far back it will allow us to bill.

By signing this agreement, you agree to receive service from Boomer Solutions Pharmacy and guarantee payment for services rendered. If payment is made to you for services rendered by Boomer Solutions Pharmacy, you will transfer the payment to Boomer Solutions Pharmacy and authorize any applicable pharmacy benefits to be paid directly to Boomer Solutions Pharmacy. You also agree to pay any legal fees and court costs incurred in the collection of this account. Signing this agreement also authorizes any third-party payer for the patient to disclose any insurance information to Boomer Solutions Pharmacy as well as authorizing Boomer Solutions Pharmacy to discuss the patient's care and information with other medical professionals involved in the patient's care in accordance with HIPAA guidelines.

CREDIT CARD

Name as it appears on card:_____ Patient Name:_____

Card #:_____ Expiration Date:_____ Security Code:_____

Card Holder's Signature_____ Date:_____

ACH DEBIT AUTHORIZATION

Account Name:_____ City:_____ State:_____ Zip_____

Bank Routing #_____ **Bank Account #**_____

Signature Of Responsible Party:_____ PrintName:_____

Attach copy of Voided check

BOOMER Rx SOLUTIONS

Patient Name: _____ Facility: _____

Patient DOB: _____ Patient SSN: _____ Medicare ID: _____

Address: _____

Phone #: _____ Email Address: _____

Primary Insurance Company Name: _____

ID: _____ Group: _____ Bin: _____ PCN: _____

Policy Holder: _____ Primary Insurance Company Phone #: _____

Secondary Insurance Company Name: _____

ID: _____ Group: _____ Bin: _____ PCN: _____

Policy Holder: _____ Secondary Insurance Company Phone #: _____

Please attach copies of the front and back of the patient's insurance cards.

*Responsible Party Name (print): _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Responsible Party (sign): _____ Print Name: _____ Date: _____

OKLAHOMA DO-NOT-RESUSCITATE (DNR) CONSENT FORM

I,_____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification to a physician or other health care provider of the health care agency or by oral notification to my attending physician; or
4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_____ or _____

Signature of Person

Signature of Representative
(Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Advance Directive Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)

This DNR consent form was signed in my presence.

_____

Date

_____ _____

Signature of Witness *Address*

_____ _____

Signature of Witness *Address*

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name _____ Date of Birth _____

Address _____ City _____

Area Code & Telephone Number _____ State _____ Zip _____

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Belfair of Shawnee to share my protected health information as set forth below, for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Persons/Organizations Authorized to Receive My Information (Name, Address, Phone & Fax)	Relationship	Purpose

B. Information to be shared

1. Check one or more boxes below.

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
☐ Entire Medical Record (includes all records except Psychotherapy Notes)
☐ Mental Health Records
☐ Alcohol or Drug Abuse Records
☐ HIV Records
☐ STD Records
☐ Progress Notes
☐ Medical Images
☐ Radiology Report(s)
☐ Cardiology Report(s)
☐ History and Physical
☐ Operation Reports
☐ Consultation Report(s)
☐ Pathology Reports
☐ Discharge Summary
☐ Physician's Orders
☐ Laboratory Report(s)

☐ Other _____

2. Covering Services Between _____ and _____ (Insert either date(s) or "all.")

III. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

☐ 12 months from the date signed in Part IV.B. ☐ Other (insert date or event): _____

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

IV. ACKNOLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. ☐ **If checked and initialed,** _____ **is authorized to share my protected health information for the purpose of marketing. I understand** _____ **may receive either direct or indirect compensation for sharing my information in this case. Individual initials** _____

3. **I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.**

4. **I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.**

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

Address of entity authorized to release information: _____

The following information is for administrative purposes and may only be completed by an entity that is a "Program" under 42 C.F.R. Part 2 with respect to alcohol and drug abuse records.

☐ If checked — disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C.F.R. Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

BELFAIR
of McAlester

ASSISTED LIVING
& MEMORY CARE

RESIDENT ACKNOWLEDGEMENT

RESIDENT RIGHTS

☐ I have received a copy and understand my rights as a resident in Belfair of McAlester community.

NOTICE OF PRIVACY PRACTICES

☐ I have received a copy of the Resident Privacy Practices

RESIDENT HANDBOOK

☐ I have received my copy of the Resident Handbook and will familiarize myself with the contents.

I HAVE READ AND INDICATE MY UNDERSTANDING AND ACCEPTANCE OF THE ABOVE BY MY SIGNATURE BELOW:

Resident Name: _____

Resident/Responsible Party Signature: _____

Date: _____

Staff Signature and Title: _____

Date: _____

BELFAIR
—of McAlester—

Dietary Restrictions Form

Name:_____ **APT#:**_____

This form must be completed and returned by _____ so that necessary eating arrangements may be made.

_____ Check here if you have **NO DIETARY RESTRICTIONS**

Please check any of the following that apply to you:

_____ Regular/Liberal

_____ Mechanical Soft

_____ No Added Salt (NAS)

_____ House Diabetic

_____ Lactose Restricted

_____ Puree

Thickened Liquids:

_____ Syrup or Nectar Consistency

_____ Honey Consistency

_____ Pudding Consistency

Other:

_____ Clear Liquid

_____ Full Liquid

Please list any food allergies:

_____

_____

_____

SIGNATURE:_____ **DATE:**_____

BELFAIR
—of McAlester—

Fitness and Exercise Release

DISCLAIMER: You should always consult with your Doctor before beginning any type of exercise or physical activity. This form is an important legal document. It explains the risks you are assuming by participating in an exercise program. It is critical that you read and understand it completely. After you have done so, please print your name legibly and sign in the spaces provided at the bottom.

Waiver, Informed Consent, and Covenant Not to Sue I have volunteered to participate in a program of physical exercise ("Program") under the direction of Belfair of McAlester staff, which may include, but not be limited to, weight and/or resistance training, cardiovascular training, flexibility and balance. THIS WAIVER AND RELEASE OF LIABILITY INCLUDES, WITHOUT LIMITATION, INJURIES WHICH MAY OCCUR AS A RESULT OF (1) MY USE OF ALL AMENITIES AND EQUIPMENT IN THE FITNESS ROOM, AND MY PARTICIPATION IN ANY ACTIVITY, CLASS, PROGRAM, PERSONAL TRAINING OR INSTRUCTION (2) EQUIPMENT THAT MAY MALFUNCTION OR BREAK (3) BELFAIR OF MCALESTER EMPLOYEE'S LACK OF SUPERVISION (4) ANY SLIPING AND/OR FALLING DROPPING OF EQUIPMENT WHILE PARTICIPATING IN ANY FITNESS PROGRAM(S).

Assumption of Risk To the best of my knowledge I am in good physical condition and have no disease, physical limitation, health concern or injury that would be aggravated or would be the cause of any injury sustained, before, during or as a result of my participating in physical activities related either directly and/or indirectly to Belfair of McAlester. I recognize that exercise might be difficult and strenuous and that there could be dangers inherent in exercise for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise does exist. These changes include abnormal blood pressure; fainting; disorders in heartbeat; heart attack; and, in rare instances, death. I understand that as a result of my participation in an exercise program, I could suffer an injury or physical disorder that could result in my becoming partially or totally disabled. I recognize that an examination by a physician should be obtained by all participants prior to involvement in any exercise program. If I have chosen not to obtain a physician's permission prior to participating in this Program, I hereby agree that I am doing so at my own risk. In any event, I acknowledge and agree that I assume the risks associated with any and all activities and/or exercises in which I participate. I acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this Program. I understand that results are individual and may vary. I ACKNOWLEDGE THAT I HAVE THOROUGHLY READ THIS WAIVER AND RELEASE AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. BY SIGNING THIS DOCUMENT, I AM WAIVING ANY RIGHT I OR MY SUCCESSORS MIGHT HAVE TO BRING A LEGAL ACTION OR ASSERT A CLAIM AGAINST BELFAIR OF MCALESTER FOR ITS NEGLIGENCE OR THAT OF ITS EMPLOYEES, AGENTS, OR CONTRACTORS.

NAME_____ SIGNATURE_____

WITNESS_____ DATE_____

Personal History Questionnaire

Name: _____

Maiden Name: _____

Name preferred to be called: _____

Date of Birth: _____

Name of personal filling out questionnaire: _____

Relationship to resident: _____

1) What age do you think your family member is living in his/her mind? _____
2) Does he/she ask for his/her spouse but does not recognize him/her? _____
3) Does he/she look for his/her children but does not recognize them? _____
4) Does he/she look for his/her mother and/or father? _____
5) Does he/she perceive him/herself as younger? _____
   - If yes, please explain _____
6) Describe the "home" your loved one remembers _____

   _____
7) Describe your family member's personality prior to the onset of the disease (outgoing, introvert, etc.). _____

   _____
8) What makes your loved one feel valued (talents, occupation, accomplishments, family, hobbies)? _____

   _____
9) What items are significant to him/her (favorite chair, sewing box, jewelry, furniture pieces, tools, purse, wallet, keys, hat, family photos, heirlooms)? Please explains the story behind each item listed.
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____

- _____
- _____
- _____

10) What is his/her morning routine (early riser, late sleeper, what areas need assistance, privacy, grooming before or after dressing, habits of a lifetime)? _____

_____

_____

11) What is his/her exact evening routine (usual bed time, snacks, specific night wear, grooming, evening/relaxing activities)? _____

_____

_____

12) What is his/her exact bathing routine (time of day, soap bar or liquid soap, washcloth, loofah, sponge bath, tub or shower, what areas need assistance, privacy)? _____

_____

13) Please list the following favorites:

Clothing (dresses, shoes, color of clothing, scarf, hats, etc.). _____

_____

Beverage(s) _____

Food/snacks _____

Music _____

TV programs _____

Movies _____

Books _____

Games _____

14) For what will he/she get cleaned/dressed up for (church, outing, friends)? _____

_____

15) What are his/her "habits of a lifetime" (daily walks, housework, nap times, usual eating times, smoking, working, etc.) _____

_____

_____

16) Please list your loved one's significant interests throughout his/her life

Age 8 to 20 _____

_____

_____

Age 20 to 40 _____

_____

_____

17) What is his/her religious background (religious affiliation, prayer time, significant spiritual symbols, traditions, favorite verses, church attendance)? _____

_____

_____

18) What is his/her cultural background? _____

19) Can he/she tell the difference between someone on TV and a real person? _____

20) Does your family member have musical ability? If yes, please describe his/her interests and talents _____

_____

21) Please describe his/her marital status and if there was more than one marriage _____

_____

22) Describe distinct characteristics of the spouse (humorous, hardworking, intelligent, etc.). _____

_____

23) What did the spouse do when they were first married (work, garden, cook, etc.)? _____

_____

24) Does he/she have any children? If yes, how many? Please list children's names and type of relationship _____

_____

_____

25) Who are significant others (who does he/she ask for or talk about) in your loved one's life? ____

_____

_____

_____

26) What type of activities do the significant others do during the day (job, run errands, volunteer work, visit family/friends, etc.)? _____

_____

27) Are there any life traumas your loved one remembers and still struggles with? Please describe.

_____

_____

_____

_____

28) What causes stress for your family member (noise, crowds, getting dressed, etc.)? _____

_____

_____

29) What calms him/her down (poetry, prayer, favorite song, massage)? _____

_____

_____

30) Please list any other information which would help us bring joy to your loved one _____

_____

_____

31) Please describe a favorite moment you have shared with your loved one _____

_____

_____

_____

32) Did he/she ever serve in the military? _____ If yes, please answer the following:

Branch of military: _____

Term and/or terms served: _____

Military achievements: _____

33) Please share any additional information which you feel is important for us to know about your loved one _____

_____

_____

_____

_____

BELFAIR
—of McAlester—
Senior Living's New Standard of Excellence

Resident Care Agreement

By Signing below, you acknowledge that you have received a copy of the RESIDENT CARE AGREEMENT and understand the agreement in full. Any and all questions can be answered by the Executive Director, the Director of Nursing or any of our Admission staff.

Resident: _____

Resident or Responsible Party: _____

Date: _____

Belfair Representative Witness: _____

802 Windsong Way • McAlester, OK 74501
918-423-7020 • BelfairOfMcAlester.com

EQUAL HOUSING OPPORTUNITY